FRANCIS HOLISTIC MEDICAL CENTER, P.C.

360 West Boylston Street, Suite 107 • West Boylston, MA 01583 •
508/854-1380

Name: _____ SSN# _____ DOB: _____

PHYSICIAN NOTICE:

Insurance companies will only pay for services that they determine to be "reasonable and necessary" under policy agreements. If an insurer determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under the program standards, the insurer will deny payment for that service. I believe that in your case, the insurer is **likely to deny** payment for:

1. Preventive Nutritional Counseling and Nutritional Educational Materials.
2. Environmental Medicine Consultations, Testing and Education.
3. Chemical Sensitivity Testing.
4. Chemical Antigen Serum Treatment Sets
5. IV Nutrient Therapy.
6. Intravenous Chelation Therapy and Associated Medical Visits.
7. Endocrine Stimulation Testing.
8. Sublingual Provocative/Neutralization Testing & Treatment.
9. Magnesium Challenge Testing.
10. Trigger Point Injections

For the above reason: The Insurer usually does not pay for this service.

BENEFICIARY AGREEMENT:

"I have been notified by my physician that he or she believes that, in my case, my insurance is likely to deny payment for the services identified above, for the reason stated. Therefore, I agree to be personally and fully responsible for payment of the indicated procedures. I agree not to seek re-imbursement from my insurance company and do not expect the Doctor's office to respond to any inquiries about this service to my insurance company.

Date	Witness	Signature	Type of Service
_____	_____	_____	alternative lab #30/kit
_____	_____	_____	_____

Date	Witness	Signature	Type of Service

CmM-Adm-30 (W) (6/6/01) cm